# Pepsi Coliseum Youth Hockey Association
# Registration Form

Name _____
(Last) (First) (MI)

Address _____
(Street) (City) (Zip Code)

Home Phone _____ Birth Date ____/____/____ Age _____

Hockey experience (# of yrs.) _____ Skating experience (# of yrs.) _____

Father's Name _____ Daytime Phone _____

Mother's Name _____ Daytime Phone _____

Preferred email address(es) _____

Any immediate emergency needs (i.e. inhaler)? _____

Other medical conditions or known allergies? Please explain. _____

_____

_____

_____

Other requests (i.e. playing with certain person or for certain coach)? _____

_____

_____

Would you like to be a parent volunteer (coach, ast. coach, team mgr., etc)? _____

**X** _____
Parent/Guardian signature

I, the parent/legal guardian of the above named child participating in the Pepsi Coliseum Youth Hockey Association (PCYHA), give my approval for his/her participation in any and all activities of the hockey program during the current season. Upon request from the team and league officials, I realize that each year the program must be completely financed by the participants of that year. Therefore, PCYHA reserves the right to collect a final assessment from each participant at the end of the season if expenses have been more than anticipated. I understand that the person signing this form will be the person considered responsible for the payment of all fees, and that should the above named child's fees become delinquent, he/she shall not be allowed to participate. I assume all risks and hazards incidental to the conduct of the activities. I further release, absolve, indemnify and hold harmless PCYHA, the organizers, sponsors and supervisors of the activities. In case of an injury to my child, I hereby waive any claims against the organizers, sponsors, or supervisors of the activities. In the event of an injury to my child and neither I nor my spouse can be immediately contacted, I do hereby grant permission to the attending physician and the hospital to render such treatment as would ordinarily be given to a patient in such condition and agree to pay the usual charges for such treatment.

**Date Paid ___/___/___ Amount Paid _____ Check # _____ Credit Card _____**

**Received by _____**